Terms

access
The ability to obtain needed health care services.

activities of daily living (ADLs)
Measures, used in an index or scale, of an individual's degree of independence in bathing, dressing, using the toilet, eating, transferring (moving from a bed to a chair), and moving across a small room. (See instrumental activities of daily living.)

adjusted average per capita cost (AAPCC)
A county-level estimate of the average cost Medicare would expect to incur for each beneficiary in the fee-for-service program. Adjustments are made so the AAPCC represents the level of spending that would occur if each county contained the same demographic mix of beneficiaries. Before enactment of the Balanced Budget Act of 1997, Medicare paid health plans 95 percent of the AAPCC, adjusted for the characteristics of the enrollees in each plan.

beneficiary
A person eligible to receive benefits under a health insurance program, such as Medicare.

capitation
A payment mechanism that pays a fixed amount per person per time period to cover services. Purchasers may use capitation to pay health plans, or plans may use it to pay providers. (See fee for service, Medicare risk contract, Medicare+Choice.)

case mix
The mix of patients treated within a particular institutional setting, such as a hospital or nursing home. Patient classification systems—such as diagnosis related groups and Resource Utilization Groups, Version III—can be used to measure hospital and nursing home case mix, respectively. (See case-mix index, diagnosis related groups and Resource Utilization Groups, Version III.)

case-mix index (CMI)
In hospitals, the average diagnosis related group (DRG) weight for all cases classified according to DRGs. The CMI is a measure of the expected relative costliness of patients' treatment in each hospital or group of hospitals. (See diagnosis related groups.)

coinsurance
A type of cost sharing in which beneficiaries and insurers share liability in a specified ratio for the established payment to a provider for a covered service. For example, Medicare beneficiaries pay coinsurance equal to 20 percent of the program's physician fee schedule amount for physicians' services. (See copayment, deductible.)

conditions of participation (COPs)
Requirements that health care facilities and organizations must meet to be eligible to receive Medicare payments.

copayment
A type of cost sharing in which beneficiaries pay a fixed dollar amount for a covered service. (See coinsurance, deductible.)

cost sharing
Payments that health insurance enrollees make for covered services. Examples of cost sharing include coinsurance, copayments, deductibles, and premiums.

deductible
A type of cost sharing in which beneficiaries must pay a specified amount for covered medical services before their insurer assumes liability for all or part of the cost of subsequent covered services. (See coinsurance, copayment.)

diagnosis related groups (DRGs)
A system for determining case mix, used by Medicare for payment in the prospective payment system (PPS) for inpatient hospital services and by some other payers. The DRG system classifies patients based on principal diagnosis, type of surgical procedure, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are intended to categorize patients into groups that are clinically meaningful and homogeneous with respect to resource use. Medicare's PPS currently uses almost 500 mutually exclusive DRGs, each of which is assigned a relative weight that compares its cost to the average for all DRGs. (See case mix, prospective payment system.)

durable medical equipment (DME)
Medical equipment that has a long duration of usefulness. Durable medical equipment is covered under Medicare Part B and includes, but is not limited to, oxygen tents, hospital beds, and wheelchairs used in patients' homes.

fee for service (FFS)
A method of paying health care providers for individual medical services, rather than paying them salaries or capitated payments. (See capitation.)

health maintenance organization (HMO)
A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically provided with limited copayments, and services are furnished through a system of affiliated providers. (See managed care.)

health plan
An organization that acts as insurer for an enrolled population. (See fee for service, managed care.)

Health Plan Employer Data and Information Set (HEDIS)
A set of standardized measures of health plan performance. HEDIS allows comparisons among plans on quality, access, and patient satisfaction; membership and use; financial information; and management. Employers, health maintenance organizations, and the National Committee for Quality Assurance developed HEDIS.

hierarchical coexisting conditions (HCCs)
A risk adjustment model that predicts health care resource use and is based on beneficiaries' diagnoses from all sites of health care. (See risk adjustment.)

home health care
Skilled nursing care, physical therapy, speech therapy, occupational therapy, medical social services, or home health aide services provided in Medicare beneficiaries' homes. The first 100 visits following an acute-care hospital stay or a skilled nursing facility stay are covered under Medicare Part A. Subsequent post-acute visits and those not preceded by a hospitalization or a stay in a skilled nursing facility are covered under Medicare Part B. There is no beneficiary cost sharing for home health services.

instrumental activities of daily living (IADLs)
Measures, used in an index or scale, of an individual's degree of independence in aspects of cognitive and social functioning, such as shopping, cooking, doing housework, managing money, and using the telephone. (See activities of daily living.)

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
A system for classifying and coding diagnoses and procedures. This system is used to facilitate the collection of uniform and comparable health information. (See diagnosis related groups.)

lifetime reserve days
If hospitalized more than 90 days for a single spell of illness, beneficiaries may draw upon a reserve of 60 days, which require a daily copayment ($384 in 1999). Each lifetime reserve day used is nonrenewable.

long-term care
Services that support, treat, and physically rehabilitate people with functional limitations or chronic conditions who need ongoing health care or assistance with activities of daily living. (See activities of daily living.)

managed care
A system of health service payment and delivery arrangements in which a health plan attempts to control or coordinate the use of health care services by its enrolled members to contain spending, improve quality, or both. Arrangements often involve a defined delivery system of providers that have some form of contractual agreement with the plan. (See health maintenance organization, preferred provider organization.)

Medicare
A health insurance program for people over 65, those eligible for Social Security disability payments, and those who need kidney dialysis or kidney transplants. (See Medicare Part A, Medicare Part B, Medicare+Choice.)

Medicare+Choice
A program created by the Balanced Budget Act of 1997 to replace the system of Medicare risk and cost contracts. During an open season each year, beneficiaries have the choice of enrolling in a Medicare+Choice plan or remaining in traditional Medicare. Medicare+Choice plans include coordinated care plans (offered by health maintenance organizations, preferred-provider organizations, or provider-sponsored organizations), private fee-for-service plans, and high-deductible plans with medical savings accounts.

Medicare Physician Fee Schedule
The resource-based fee schedule Medicare uses to pay for physicians' services.

Medicare Part A
Also called hospital insurance. This part of the Medicare program covers the cost of hospital stays and related post-hospital services. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries are responsible for an initial hospital deductible per spell of illness and for copayments for some services.

Medicare Part B
Also called supplementary medical insurance. This part of the Medicare program covers the cost of physicians' services, outpatient laboratory and X-ray tests, durable medical equipment, outpatient hospital care, and certain other services. This voluntary program requires payment of a monthly premium, which covers about 25 percent of program costs, with general revenues covering the rest. Beneficiaries are responsible for an annual deductible and for coinsurance payments for most covered services.

Medicare risk contract
A contract between Medicare and a health plan under which the plan receives monthly capitated payments to provide Medicare-covered services for enrollees and thereby assumes insurance risk for those enrollees. (See Medicare+Choice.)

medigap policy
A private insurance policy designed to complement Medicare coverage. All medigap policies sold after July 31, 1992, must provide one of ten uniform benefit packages, which range from covering most of Medicare's copayment and coinsurance requirements to covering all Medicare cost sharing plus some services not covered by Medicare.

noncash transfer
A transfer from government to individuals of specific goods or services rather than cash. Medicare is a noncash transfer of medical care.

nursing facility (NF)
An institution that provides skilled nursing care and rehabilitation services to injured, functionally disabled, or sick persons; or regularly provides health-related services to individuals who, because of their mental or physical condition, require care and services that can be made available to them only through institutional facilities. In the past, certification distinctions were made between a skilled nursing facility and an intermediate care facility (the latter was certified only to furnish less-intensive care to Medicaid recipients). The Omnibus Budget Reconciliation Act of 1987 eliminated that distinction by requiring all nursing facilities to meet skilled nursing facility certification requirements for Medicare purposes. (See skilled nursing facility.)

outliers
Cases that substantially differ from the rest of the population of cases. With regard to hospital payment, outliers are identified as cases with extremely high costs compared with the prospective payment rate in the diagnosis related group. Hospitals receive additional payments for these cases under the prospective payment system. (See prospective payment system.)

peer review organization (PRO)
A state-based organization, also known as a quality improvement organization, that undertakes Medicare quality improvement and peer review activities under contract to the Health Care Financing Administration (HCFA). Quality improvement organization is the term preferred by the organizations themselves, although peer review organization is the term used in legislation, regulations, and publications by HCFA.

preferred provider organization (PPO)
A managed care plan that contracts with networks or panels of providers to furnish services and be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list but may use non-network providers as well. (See managed care.)

premium
An amount paid periodically to purchase health insurance.

principal inpatient diagnosis-diagnostic cost group (PIP–DCGs)
A risk adjustment method that is the basis for the interim risk adjustment system for Medicare+Choice payment rates. Beneficiaries' relative health status is measured using the principal diagnoses of inpatient hospitalizations. The model is prospective, meaning that payments in a year are based on inpatient hospitalizations during the previous year.

private contracting
A physician payment option created by the Balanced Budget Act of 1997. Under private contracts, beneficiaries agree to pay full charges directly to physicians, and no bills are submitted to Medicare. Physicians who enter into these contracts cannot submit bills to Medicare for any patient for a period of two years.

prospective payment system (PPS)
A provider's payment is based on predetermined rates and is unaffected by its incurred costs or posted charges. Examples of prospective payment systems include the one Medicare uses to pay hospitals for inpatient care and the physician fee schedule.

Qualified Medicare Beneficiary (QMB)
This Medicaid program pays for Medicare premiums, deductibles and coinsurance for beneficiaries with incomes at or below the federal poverty level. Some beneficiaries may also qualify for full Medicaid benefits under state laws.

quality improvement organization (QIO)
A state-based organization, also known as a peer review organization, that undertakes Medicare quality improvement and peer review activities under contract to the Health Care Financing Administration (HCFA). Quality improvement organization is the term preferred by the organizations themselves, although peer review organization is the term used in legislation, regulations, and publications by HCFA.

Quality Improvement System for Managed Care (QISMC)
Health care quality measurement, reporting, and improvement requirements for health plans participating in Medicare+Choice.

Resource Utilization Groups, Version III (RUG–III)
A system for determining case mix in nursing facilities. The RUG–III system classifies patients based on functional status (as measured by an index of activities of daily living) and the number and types of services used. Each RUG has a nursing index or weight indicating the average level of resources needed to provide nursing services to patients in the group. Rehabilitation RUGs also have indexes indicating the average levels of resources required to furnish therapy services. (See case mix, activities of daily living.)

risk adjustment
The process used to adjust health plan payments to compensate for differences in expected spending on enrollees in different plans.

risk selection
Any situation in which health plans differ in the health risks associated with their enrollees because of enrollment choices made by the plans or the enrollees. Health plans' expected costs vary because of underlying differences in health and use of services in their enrolled populations.

risk sharing
A method of providing additional payment amounts for high-cost patients or to offset plan losses, for example, stop loss policies that provide additional payments once a spending threshold has been reached.

skilled nursing facility (SNF)
An institution that has a transfer agreement with at least one hospital, that provides primarily inpatient skilled nursing care and rehabilitative services, and that meets other specific certification requirements.

Specified Low-Income Medicare Beneficiary (SLMB)
This Medicaid program pays the Medicare Part B premium for Medicare beneficiaries with incomes between 100 and 120 percent of the Federal poverty level.

supplemental insurance
Health insurance held by Medicare beneficiaries that covers part or all of the program's cost-sharing requirements and some services not covered by traditional Medicare. Beneficiaries may obtain these policies as a retirement benefit from a former employer or by individual purchase. (See medigap policy.)